TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, D.C.

Respondent Name
Arch Insurance Company

MFDR Tracking Number
M4-16-2046-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Previous Designated Doctor MMI certification does not negate the injured employee's entitlement to subsequent MMI/IR evaluations by certified doctor. [The injured employee] was initially evaluated by request for the purpose of providing an Alternative MMI/IR evaluation in order to dispute a DD evaluation."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on March 25, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2015	Referral Doctor's Examination to Determine Maximum Medical Improvement & Impairment Rating	$350.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
   - Note: "PATIENT HAS ALREADY REACHED MMI PER DESIGNATED DOCTOR EXAM PERFORMED ON 11/24/2014."

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed service?
3. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P13 – "Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies," and stating, "PATIENT HAS ALREADY REACHED MMI PER DESIGNATED DOCTOR EXAM PERFORMED ON 11/24/2014."

   Texas Labor Code §408.0041(f-2) provides that:

   > An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement and the employee's impairment rating from the treating doctor or from another doctor to whom the employee is referred by the treating doctor if:
   > (1) the designated doctor's opinion is the employee's first evaluation of maximum medical improvement and impairment rating; and
   > (2) the employee is not satisfied with the designated doctor's opinion.

   Therefore, the determination that a designated doctor previously placed the injured employee at maximum medical improvement does not preclude the injured employee from seeking an alternate opinion. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.204(j)(2)(A),

   > If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

   Paragraph (3) states, "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of MMI and found that the injured employee was not at MMI. Therefore, the correct MAR for this examination is $350.00.

3. Texas Labor Code §408.0041(h) states:

   > The insurance carrier shall pay for:
   > (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner …

   The division finds that the services in question were not prohibited. The total MAR for the disputed service is $350.00. The insurance carrier paid $0.00. A reimbursement of $350.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.